No one will be denied access to services due to inability to pay.

A discounted/sliding fee schedule is available based on family size and income.

Healing Stones Family Counseling Service

Annual 2025 Poverty Guidelines

Household/Family Size	100%	125%	200%
1	$15,650	$19,563	$31,300
2	$21,150	$26,438	$42,300
3	$26,650	$33,313	$53,300
4	$32,150	$40,188	$64,300
5	$37,650	$47,063	$75,300
6	$43,150	$53,938	$86,300
7	$48,650	$60,813	$97,300
8	$54,150	$67,688	$108,300
9	$59,650	$74,563	$119,300
10	$65,150	$81,313	$130,300

Clinical	25%	35%	50%
Substance Use	20%	35%	55%

Retrieved from: Income Guidelines - South Carolina Legal Services

SLIDING FEE SCALE **APPLICATION FORM**

Today's Date		Name					
Date of Birth		Address					
City				State		ZIP Code	
Home Phone		Work Phone				Cell Phone	

Would you like to schedule an appointment with a Certified Enrollment Counselor to see if you and/or household members are eligible for subsidized health insurance? ☐ **Yes** ☐ **No**

Applying for health coverage is NOT a prerequisite for Sliding Fee Scale Discount eligibility.

Please list all immediate family members and persons living in your household (spouse or life partner and children that are *under the age of 21 years)* and that are dependent on family income. Please do not include guests, elderly parents or roommates.

Name of Family Members	Sex	Date of Birth	'X' if no health insurance	Has insurance? Type: Medi-Cal (MC), CMSP, Path 2 Health, Covered California or 'Other' (please specify)
1. (Self)				
2. (Spouse)				
3. (Child)				
4. (Child)				
5. (Child)				

What is your gross family income BEFORE deductions (please include all working adults, above age 21)?

Name of Household member receiving income	Estimated Annual income (per person) (Monthly Income x 12)	Sources of Income (employment, Social Security, pension/ retirement, workers comp, child support, alimony, etc.)	Proof of Income Date Requested/ Date Verified	PHC Staff Notes
1. (Self)	$			
2.	$			
3.	$			

I certify that the income and household composition information is true and correct to the best of my knowledge. I have read the Sliding Fee Scale Discount Application and I will abide by all Sliding Fee Scale Discount requirements.

Applicant Signature		Date	

Please bring your proof of income within 7 days of submitting application.

STAFF USE ONLY

PHC Staff: _____ Date: ____ ____ S/S Termination Date _____

Per your estimated monthly income of $_____and a family size of _____ of your qualify for SS level _____ (7days)

Based on your monthly income of $_____ and a family size of _____ you qualify for SS level _____ (12 months)

For each office visit, patient will pay: _____ plus laboratory fees, medications, and supplies at cost.